ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for the HIPAA 270 Eligibility Request and 271 Eligibility Response Transactions

DRAFT VERSION 1.5
APRIL 2006

Revision History

Date	Version	Description	Author
11/22/2002	1.0	Draft EPP document posted to the AHCCCS Web Site	AHCCCS Information Services Division
06/17/2003	1.1	Draft document for Web-based eligibility requests and responses posted to the AHCCCS Web Site	AHCCCS Information Services Division
07/30/2003	1.2	Draft document for online and batch HIPAA 270/271 Transactions for use in Transaction and Code Set implementation. Posted to the AHCCCS Web Site.	AHCCCS Information Services Division
11/04/2003	1.3	Draft document for 270/271 Transactions for use in Transaction and Code Set implementation.	AHCCCS Information Services Division
12/11/2003	1.4	Final document for 270/271 Transactions for use in Transaction and Code Set implementation	AHCCCS Information Services Division
03/04/2004	1.4.1	Amended final document for 270/271 Transactions for use in Transaction and Code Set implementation	AHCCCS Information Services Division
07/27/2005	1.4.2	Amended final document with clarifications identified through AHCCCS HIPAA Workgroup	AHCCCS Information Services Division
04/04/2006	(Draft) 1.5	Add NPI requirements and verify document contents.	AHCCCS Information Services Division

270/271 Companion Document
Change Summary

#	Location	Previously Stated	Revision
1	V 1.5 Document	None	Added Change Summary
2	V 1.5 Introduction, Document Purpose	-	Removed references to 276/277 Claims Status Transaction set and 278 Prior Authorization Transaction
3	V 1.5 Various pages	Provider	Replaced various references to "provider" with "trading partner"
4	V 1.5 Various pages	None	Added references to ftp server where appropriate
5	V 1.5 Section 5.3 Error Codes	-	Moved list of HIPAA Compliant Reject Reason Codes and messages to new Appendix A. Changed various references to point to Appendix A.
6	V 1.5 Section 4, Size of Transmissions/Batches	On interactive 270/271 Transactions, a request can only be made for one patient at a time. This is the limit recommended by the HIPAA Implementation Guide and adopted by AHCCCS.	Added statement regarding limit of 10,000 requests per transaction set for batch mode.

Table of Contents

1. Introduction

1.1 Document Purpose

Companion Documents

Companion Documents are available to external entities (health plans, program contractors, providers, third party processors, and billing services) to clarify the information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- *270 Eligibility Request and 271 Eligibility Response Transactions*
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 837 and NCPDP Encounter Transactions
- U277 Unsolicited Encounter Status Transaction

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. The intent of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of electronic data interchange standards in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were not imposed arbitrarily but were developed by processes that included significant public and private sector input.

Covered entities are required to accept HIPAA Transactions in the standard format in which they are sent and must not delay a transaction or adversely affect an entity that wants to conduct the transactions electronically. Both AHCCCS and its trading partners are HIPAA covered entities.

Document Objective

This Companion Document provides information about the Web-based 270 Eligibility Request and 271 Eligibility Response Transactions that is specific to AHCCCS and AHCCCS trading partners. For these transactions, the document describes the data submitted to AHCCCS by trading partners when they make electronic eligibility requests and the data sent by AHCCCS in response.

Intended Users

Companion Documents are intended for members of the technical staffs of external entities who are responsible for electronic transaction/file exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for format, content, and field values can be found in the Implementation Guides. This document describes the AHCCCS 270/271 Web environment and batch 270/271 Transactions, including edit and interchange conventions. The document also provides specific information on the fields and values required for transactions sent to or received from AHCCCS.

Companion Documents are intended to supplement rather than replace the standard HIPAA Implementation Guide for each transaction set. Information in these documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is intended to be a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and either the health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize conflicts or errors; however, AHCCCS, the AHCCCS Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions.
Transaction Standards	Section 4 provides information relating to the transactions included in this Companion Document including: ▪ General HIPAA transaction standards ▪ Information on the syntactical edits that the AHCCCS translator applies to batch 270 Eligibility Request Transaction ▪ Data interchange conventions applicable to the transactions
Transaction Specifications	Section 5 provides more specific information relating to the transaction included in this Companion Document including: ▪ A statement of the purpose of transaction specifications for electronic interchanges between AHCCCS and other HIPAA covered entities ▪ Detailed Specifications that show how AHCCCS expects to receive 270 Eligibility Request Transactions and populate data elements in 271 Eligibility Response Transactions when AHCCCS uses transaction data elements in ways that are not fully described by the HIPAA Implementation Guide.

2. 270/271 Eligibility Verification Transactions

2.1 Transaction Overview

Eligibility Verification for AHCCCS Recipients

Like other health care payers, AHCCCS enables authorized trading partners to quickly determine whether patients are eligible for benefits. In the pre-HIPAA environment, eligibility verification was accomplished in the following ways:

- By person-to-person phone calls to the AHCCCS Eligibility Verification Unit
- By phone calls to the automatic Interactive Voice Response (IVR) System
- By dial-up connections to the Eligibility Verification System (EVS) maintained by an AHCCCS contractor
- By swipe card interfaces with the Eligibility Verification System (EVS) maintained by an AHCCCS contractor
- By a Web-based recipient eligibility verification system maintained on the AHCCCS Web Site

These methods of eligibility verification are supplemented (or, in the case of the Web-based transactions, replaced) by the interactive and batch Web-based 270/271 Transactions developed by AHCCCS and described in this Companion Document.

Interactive Web-based Transactions

The interactive or online versions of the transactions replace the pre-HIPAA, Web-based eligibility verification system with transactions that are data content compliant as defined in the Final Rule for HIPAA Transactions and Code Sets. Interactive Web-based eligibility verification transactions include all HIPAA data elements that are required for the sake of data content. For Requests errors, the interactive Response Transaction responds with the Reject Reasons (but not the codes themselves) specified in the 270/271 HIPAA Implementation Guide.

Interactive 270 Request Transactions are limited to one patient (2100C Subscriber Name Loop) per transaction. There is no limit, however, to the length of the date range for which information can be requested or to the number of Eligibility, Enrollment, Medicare, and TPL segments that can be returned on a 271 Response Transaction. A special feature of interactive

Eligibility Responses is use of the Request From Date as the Begin Date for a period of eligibility or enrollment that actually begins prior to the Request From Date.

Batch Web-based Transactions

Batch 270/271 Transactions are data format as well as data content compliant with HIPAA Transaction and Code Set requirements. Batch eligibility verification submitters submit 270 Transactions with any number of 2000C Subscriber Level Loops, each 2000C Loop containing within it a single 2100C Subscriber Name Loop (and subservient loops) for a separate eligibility inquiry.

AHCCCS will accept one batch web-based 270 Transaction file per day per Web User ID. The Web User ID is assigned during the account creation process. If a second file is submitted within the same day with the same Web User ID, the second file will overlay the first file.

AHCCCS will accept multiple batch 270 files per day via the ftp server. On the day after submission of batch requests that pass the translator's syntactical edits, AHCCCS posts to its Web Server or ftp server a 271 Response Transaction for each 270 Request that each requesting trading partner submitted to it. Response transactions can be both downloaded into requester systems and displayed online by requesters. In either mode, eligibility responses carry identification, demographic, eligibility, enrollment, Medicare, and TPL information about recipients. Responses use HIPAA Reject Reason Codes and related data elements to tell requesters when information is not available (e.g., "Patient not Found"). Each of the patient eligibility requests on a batch 270 Transaction gets some kind of response on the 271 Transaction returned by AHCCCS.

There is no limit to the length of the date range for which information can be requested or to the number of Eligibility, Enrollment, Medicare, and TPL segments that can be returned on a batch 271 Response Transaction. Unlike interactive eligibility responses, batch 271 Responses always return the eligibility and enrollment Begin and End Dates maintained in PMMIS.

Processes Replaced or Impacted

270/271 Eligibility Request and Response Transactions

Replaced Files
Pre-HIPAA Web-based Request and Response Transactions

Impacted Files
None

2.2 270/271 Recipient Eligibility Request and Response Transactions

Standard Implementation Guide

The standard Implementation Guide for the 270/271 Transaction Set is the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 Transaction Set Implementation Guide for the Health Care Eligibility Inquiry and Response Transactions and all approved Addenda. Versions of the 270/271 Implementation Guide and Addenda adopted by AHCCCS and other covered entities and used in preparation of this document are:

- ASC X12N 270/271 (004010X092)
- ASC X12N 270/271 (004010X092A1) (Addenda)

270 Eligibility Request Transaction

Interactive 270 Requests

The interactive or online Web-based eligibility request transaction consists of a basic set of data elements used to identify AHCCCS recipients, plus additional data elements required by HIPAA. Recipient identification data elements serve as search criteria for recipient eligibility information within one of the following sets:

- AHCCCS Recipient ID (set of one)
- Recipient Social Security Number (set of one)
- Recipient Last Name, Recipient First Name, Recipient Date of Birth, and Recipient Gender (set of four)

In addition to a set of one or more search criteria, a Service Begin Date is required. Optionally, a Service End Date can also be submitted. Data returned on 271 Response Transaction falls upon or within the Service Date(s) on the request. For the Name/DOB/Gender criteria set, exact matches are required.

AHCCCS edits reject 270 Requests with invalid data (e.g., an invalid Date of Birth). In the interactive mode, requests can be submitted for only one patient at a time.

Batch 270 Requests

In the batch mode, the same recipient search criteria and eligibility date determinations are used on incoming 270 Transactions, but without the one patient per 270 Request limitation necessary for immediate response in the interactive mode. Like interactive Requests, batch 270 Requests can be for any date or date range.

Data elements in the batch 270 Transaction occur within the transaction's format as documented in the 270/271 Implementation Guide. They include control and qualifier data elements that are not needed in the interactive version of the transaction.

The batch transaction is HIPAA compliant in terms of both data format and data content. AHCCCS offers this transaction, without charge, to trading partners that want to submit eligibility requests as HIPAA compliant transactions. Trading partners can also submit HIPAA compliant 270/271 Transactions to the AHCCCS EVS contractor but fees may apply.

271 Eligibility Response Transaction

Interactive 271 Responses

Like the interactive 270 Request Transaction, the interactive 271 Response is data content but not data format compliant with HIPAA Transaction and Code Set requirements. Data content compliance is what the Final Rule asks of Web-based data interchanges that are considered "person-to-computer" rather than "computer-to-computer" exchanges of data. Since most of the data transmitted on interactive eligibility responses does not require translation, interactive eligibility responses do not differ greatly from the pre-HIPAA environment. The same one-patient-per-request limitation continues to apply.

Batch 271 Responses

Batch 271 Eligibility Verification Responses are both data content and data format compliant with HIPAA Transaction and Code Set requirements. Eligibility responses with a 2000C Loop for each patient are posted to the AHCCCS Web Server. Each 2000C Loop and loops subservient to it carry identification, demographic, eligibility, enrollment, Medicare, and TPL information within a requested date or date range or, alternately, a Reject Reason Code and associated data elements that say why a patient eligibility request cannot be processed. Batch responses can be viewed online or downloaded to the requester's system in 271 format.

Recipient data in batch Web-based 271 Transactions is more extensive than data in interactive eligibility responses. Most of the same HIPAA compliant Reject Reason Codes and associated data elements appear on batch 271 Responses as are on interactive Responses. Further information can be found in Section 5.3, 271 Eligibility Response Transaction Specifications.

Related Transactions

270/271 Eligibility Request and Response Transactions are related to the 276/277 Claims Status Request Transactions Set. AHCCCS will make the 276/277 Transaction Set available in the future in both interactive and batch modes.

Transmission Schedules

Web-based interactive eligibility requests can be submitted at any time of the day or night. Responses are immediate, except for down times needed by PMMIS for production recycling. These downtimes are from 4:00 to 4:15 AM on weekdays and from Midnight to 7:00 AM the next morning on Friday and Saturday nights.

Batch 270 Request Transactions should be posted to the AHCCCS Web or ftp Server by 4:00 PM with 271 Response Transactions returned by AHCCCS by 8:00 the next morning. If a Request Transaction has syntactical errors, the transaction and all the recipient requests in it, are rejected with a file error message by the AHCCCS translator. The rejection message is posted to the Web Server.

Batch 271 Response Transactions are retained on the AHCCCS Web Server for a period of five days and then deleted. Batch transactions are retained on the AHCCCS ftp server for 30 days before deletion.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

AHCCCS Data Center Communications Requirements

Authorized users of 270 and 271 Eligibility Transactions submit 270 Request Transactions and view and download 271 Response Transactions from the AHCCCS Web Server. To access the Server, an eligibility verification requester needs a User Name and Password. All valid AHCCCS providers can obtain unique User Names and Passwords from the AHCCCS Web Site (http://www.ahcccs.state.az.us/). To do this, they must enter an AHCCCS assigned Provider ID Number and a Federal Tax ID Number in order to create an account.

AHCCCS verifies provider identification data before creating an account and assigning a User Name and Password. AHCCCS notifies providers of their User Names and Passwords by regular mail. Providers cannot make interactive or batch eligibility requests until they receive authorization letters. Web-based encryption software provides additional security.

Additional information about the account creation process for 270/271 Eligibility Verification Transactions can be found on the AHCCCS Web Site (http://www.ahcccs.state.az.us/). To set up an account for batch processing, please contact the AHCCCS HIPAA Workgroup via email at AHCCCSHIPAAWorkgroup@ahcccs.state.az.us .

Technical Assistance and Help

The AHCCCS Information Services Division (ISD) Customer Support Center provides technical assistance for electronic data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (setup, procedures, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

3.2 File Naming Conventions

File Naming Conventions (Web Batches)

270 Transaction Overview

```
AZ-270-20031113-01-020107-4005      Batch 270 Request
^  ^      ^     ^    ^     ^
|  |      |     |    |     |
|  |      |     |    |     `--------Web ID
|  |      |     |    `--------------Provider ID
|  |      |     `-------------------File Type
|  |      `-------------------------Submission Date
|  `--------------------------------Transaction Code
`-----------------------------------State Code
```

Web Batch 270 Request

The batch 270 request transaction is HIPAA compliant in terms of both data format and data content. Refer to Section 2.2, 270/271 Recipient Eligibility Request and Response Transactions, Batch 270 Requests, for more information.

AZ-270-YYYYMMDD-PROVID-WEBID

- AZ is the state code.
- 270 is the Transaction code.
- YYYYMMDD is the submission date.
- 01 is the Batch 270 Request.
- PROVID is the Provider ID.
- WEBID is the Web User ID assigned during the account creation process.

File Naming Conventions (FTP Batches)

FTP Batch 270 Request

There is no required naming convention for FTP Batch 270 Requests at this time.

271 Transactions Overview

```
AZ-271-20031113-01-020107-4005      Batch 271 Responses
AZ-271-20031113-02-020107-4005      Interactive 271 Responses
AZ-271-20031113-03-020107-4005      Syntactical Error Report
^  ^      ^     ^    ^     ^
|  |      |     |    |     |
|  |      |     |    |     `--------Web ID
|  |      |     |    `--------------Provider ID
|  |      |     `-------------------File Type
|  |      `-------------------------Process Date
|  `--------------------------------Transaction Code
```

```
`---------------------------------State Code
```

Web Batch 271 Responses:

This is the batch 271 response file available for download (in X12 format). Refer to Section 2.2, 270/271 Recipient Eligibility Request and Response Transactions, Batch 271 Responses, for more information.

AZ-271-YYYYMMDD-01-PROVID-WEBID

- AZ is the state code.
- 271 is the Transaction code.
- YYYYMMDD is the process date.
- 01 is the Batch 271 Responses.
- PROVID is the Provider ID.
- WEBID is the Web User ID assigned during the account creation process.

FTP Batch 271 Responses:

The FTP Batch 271 Response is only available in X12 format. It is named as follows:

YYMMDD.999999999.271

- YYMMDD is the process date.
- 999999999 is a sequential number
- 271 is the transaction ID

The file is place in the submitter's assigned outbound directory.

Interactive 271 Responses

The Interactive 271 Responses is the Batch 271 Responses in a viewable web format. This allows the user to view the results of the 270 Request without performing the download process. Refer to Section 2.2, 270/271 Recipient Eligibility Request and Response Transactions, Interactive 271 Responses, for more information.

AZ-271-YYYYMMDD-02-PROVID-WEBID

- AZ is the state code.
- 271 is the Transaction code.
- YYYYMMDD is the process date.
- 02 is the Interactive 271 Responses.

- PROVID is the Provider ID.
- WEBID is the sequence number assigned by AHCCCS during transaction processing.

Syntactical Error Report

Batch 270 Transactions are edited by the translator and rejected if they have syntactical errors. This report identifies the syntactical error found. Refer to Section 4.3, Translator Edits for Batch 270 Eligibility Request Transactions, for additional information regarding this report.

AZ-271-YYYYMMDD-03-PROVID-WEBID

- AZ is the state code.
- 271 is the Transaction code.
- YYYYMMDD is the process date.
- 03 is the Syntactical Error Report.
- PROVID is the Provider ID.
- WEBID is the sequence number assigned by AHCCCS during transaction processing.

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in the Implementation Guide for each mandated transaction and modified by authorized Addenda. Currently, the 270/271 Eligibility Request and Response Transaction Set has a draft Addendum (although, for these transactions, it is brief and has little impact). It has been adopted as final and used in AHCCCS requirements for the 270/271 Transaction Set.

Size of Transmissions/ Batches

Transmission sizes can be limited based on two factors:

- The number of segments recommended by HIPAA Implementation Guides
- AHCCCS file transfer limitations

On interactive 270/271 Transactions, a request can only be made for one patient at a time. This is the limit recommended by the HIPAA Implementation Guide and adopted by AHCCCS. In the batch mode, the HIPAA Implementation Guide recommends a maximum of ninety-nine requests in any given transaction set, and while AHCCCS will accept a reasonable number of requests above that limit, the number should not exceed 10,000 requests per transaction set whenever possible. AHCCCS reserves the right to not process 270 transaction sets which exceed this number of requests within the set.

For postings to the Web Server, AHCCCS has a file length limitation of one megabyte. There is no limit using the ftp option beyond the limit imposed by the number of requests per transaction set.

Other Standards

Eligibility Request and Response Tracking

In the interactive mode, each eligibility request is for a single individual and is answered by a single immediate response. Tracking of individual patients on requests and responses is not necessary. In the batch mode, however, any number of individual recipients can be included in a single 270 Transaction with response from a single 271.

Individual recipients on batch 271 Responses always appear in the sequence in which they are submitted on 270 Requests. In addition, a submitter created Trace Number (TRN03) for each patient is returned on the 271 Response. The Trace Number facilitates matches between patient level request and response data on 270 and 271 Transactions.

Since some requests for individual recipients may be valid and others not, AHCCCS recommends that batch 270 requesters retain their 270 Requests and compare them with 271 Responses in order to track requests and responses at the recipient level. When a request for an individual recipient cannot be processed, AHCCCS returns an AAA Request Validation Segment with an error code in the 2000C Loop of the 271 Transaction.

4.2 Testing Procedures

Testing Procedures

Unlike Claim and Encounter Transactions that make extensive updates to PMMIS Databases, 270 Transactions are for inquiry only and, as used by AHCCCS, do not change data in PMMIS. For this reason, AHCCCS does not require testing with trading partners for Web-based 270 and 271 Transactions.

Both the AHCCCS translator and PMMIS identify problems with 270 Eligibility Verification Requests and report them in the following ways, depending on the kind of error:

- With a transmission level error Response Code and File (batch transactions only) – Requesters can correct the problem indicated by the rejection file and, in consultation with AHCCCS, resubmit the transaction.

- With HIPAA compliant Reject Reasons or Codes on 271 Response Transactions (Reject Reason Codes on batch transactions and Reject Reasons on online transactions)

Although AHCCCS does not require preliminary testing of data exchanges that involve the 270/271 Transaction Set, trading partners may wish to submit production-level requests in a test mode to ensure that all aspects of the interchange are working correctly. Batch 270 Transactions that trading partners post to the AHCCCS Web Server without their being data content and format compliant are rejected by the AHCCCS translator with a transmission level rejection message.

4.3 Translator Edits for Batch 270 Eligibility Request Transactions

Overview of the Translator Edit Process

Edits performed by the AHCCCS translator on batch 270 Eligibility Request Transactions ensure that incoming transactions comply with the standards documented in the transaction's HIPAA Implementation Guide. These syntactical edits are separate from and in addition to edits performed by Web software or by PMMIS as the system responds to interactive or batch eligibility requests. Interactive transactions do not have to pass through the translator because they need be only data content compliant rather than data content and data format compliant to HIPAA Transaction and Code Set standards.

Batch 270 Transactions are edited by the translator and rejected if they have syntactical errors. Requesters receive a rejection message on the AHCCCS Web Server and call the AHCCCS Customer Support Center when they require additional information.

The syntactical error report lists the sender and receiver information followed by the error message. In most cases for the 270, the message will be either:

Interchange 1 is a duplicate Interchange Control Number
or
The following data did not pass X12 validation when checked against X12Mail.mtt

Sample Syntactical Error Report:

```
X12 Error     ThreadID: 468000000120031029000oi
October 29, 2003  - 13:13:12

PASSX12.mmc -

Sender ISA Qual/ID : ZZ00162
Sender App ID : NA
Receiver ISA Qual/ID : ZZAHCCCS866004791
Receiver App ID : NA
The following data did not pass X12 validation when checked
against X12Mail.mtt
```

The four translator edit types in use by AHCCCS are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must present).

The list of 997 Data Element Syntax Error Code (AK403) values in Appendix B of every HIPAA X12 Implementation Guide gives a more specific idea of what these testing and edit types mean in practice.

Standards for the translator are based on HIPAA Implementation Guides and are not specific to AHCCCS. Other X12 trading partners can be expected to use the same conventions.

4.4 Batch Data Interchange Conventions

Overview of Data Interchange

When receiving batch 270 Transactions and returning 271 Transactions to batch requesters, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 270 and 271 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Specifications that specify how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes are shown in the table beginning on the next page. Note that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS Web Server and not through the ISA Segment.

Outer envelopes are needed in the batch mode for both 270 Transactions submitted by trading partners and 271 Transactions generated by AHCCCS in response. In the interactive mode, they are not necessary. The Control Envelope Specifications in this section covers both 270s and 271s.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Translation Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The valid data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Characters	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 characters	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 characters		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 characters		For 270 Request Transaction, the Provider ID assigned by AHCCCS to the trading partner. For 271 Response Transactions, “AHCCCS” followed by the nine-digit AHCCCS Federal Tax ID number (866004791)
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 characters	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 characters		For 270 Request Transactions, “AHCCCS” followed by the nine-digit AHCCCS Federal Tax ID number (866004791) For 271 Response Transactions, the Provider ID assigned by AHCCCS to the trading partner.
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 characters		The Interchange Date in YYMMDD format

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 characters		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 characters	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		The Interchange Control Number. ISA13 must be identical to the control number in associated Interchange Trailer field IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	No Acknowledgement Requested AHCCCS does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the AHCCCS translator will receive them and notify AHCCCS staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters are defined by usage in the ISA Segment and do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions: Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						– hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 characters		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 characters		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HS HB	Eligibility, Coverage or Benefit Inquiry (270 Requests). Eligibility Coverage or Benefit Information (271 Responses)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		For 270 Request Transactions, the Provider ID assigned by AHCCCS to the trading partner. For 271 Response Transactions, "AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		For 270 Request Transactions, "AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number For 271 Response Transactions, the Provider ID assigned by AHCCCS to the trading partner.	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		004010X092A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set

Loop ID	Seg ID	Element ID	Element Name	Element Definition/Length	Valid Value	Definition/Format	Source
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

Interchange Flows and Acknowledgments

The following diagram, AHCCCS Interchange Flow for the 270/271 Transaction Set, shows the relationships between AHCCCS and trading partners who submit online and batch Web-based patient eligibility requests. All requests and responses go through the AHCCCS Web Server. Only batch requests and responses, however, require translation and pass through the AHCCCS Translator.

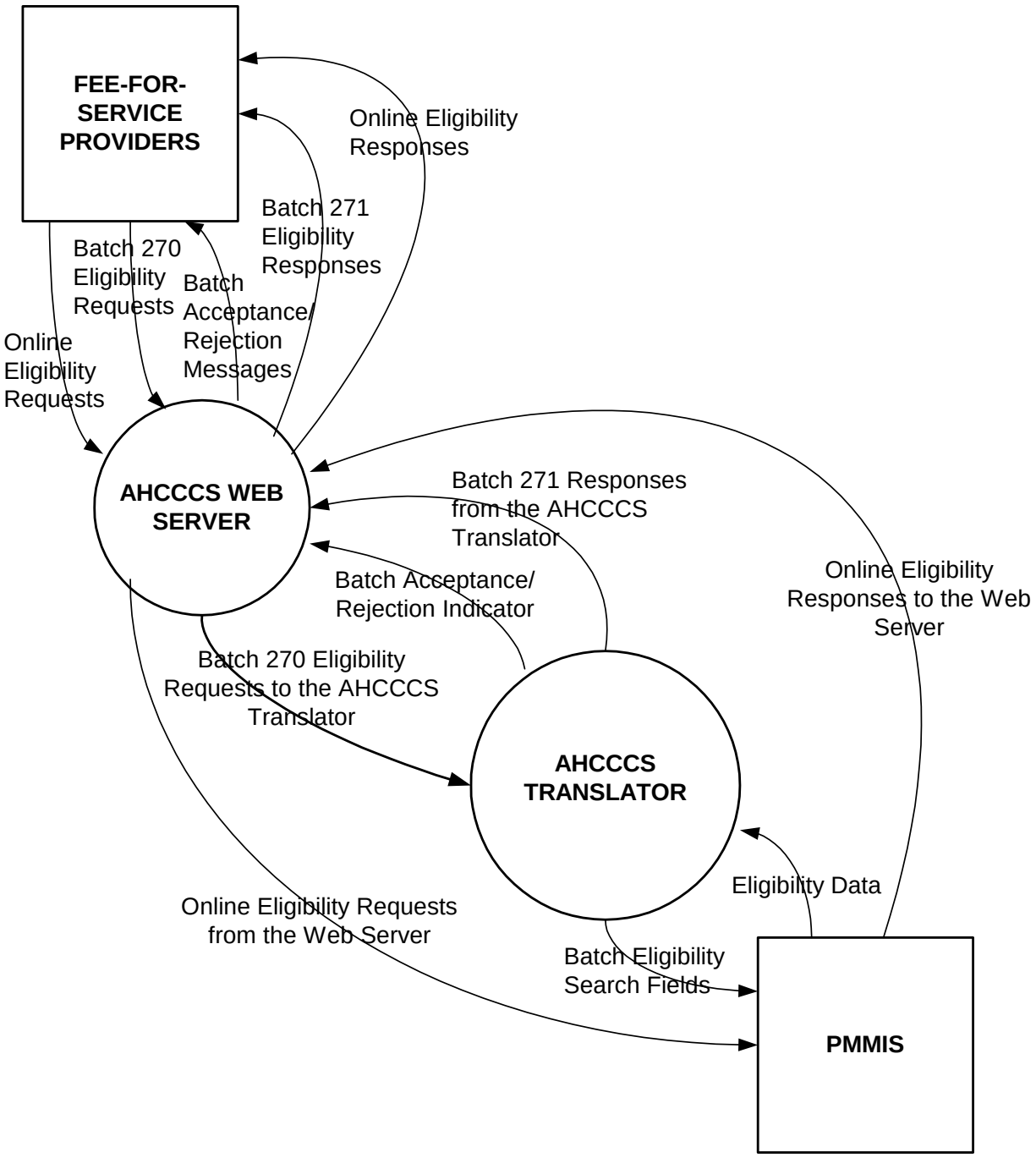
The batch 271 Response Transactions that leave AHCCCS are subject to the same kinds of translator edits as incoming 270 Requests. Transactions from AHCCCS that fail translator edits are corrected prior to transmission.

The diagram shows both online or interactive eligibility verification transactions and batch 270/271 Transactions with next day turnaround. In the diagram, the online transactions are on the outside of the groups of data flows and the batch transactions are on the outside. When the translator detects syntactical errors on the 270 Transaction, an error Response Code ("03") is returned to the Web Server with a file of technical error information. If the transmission (equivalent to a file) is accepted, each individual patient request on it is processed by PMMIS and included in the batch 271 Response.

Within the batch Response, valid patient requests receive data on requested recipients within requested date periods. Invalid requests receive AAA Request Verification Segments with patient level Reject Reason Codes. These codes and the descriptive Reasons associated with them tell the requester that an AHCCCS recipient cannot be found or that a search field on the 270 is invalid. Receivers of 271 Transactions that include responses to invalid patient requests can use data in Subscriber Trace Number TRN Segments to match requests and to compare 271 Reject Reason Codes with search criteria on 270 requests. Trading partners can then identify and correct the problems, and include the corrected requests on new 270 transmissions.

Online responses use HIPAA Reject Reasons rather than the codes themselves on response transactions. The online situation is less complex because responses are immediate and online requests can be submitted for only a single patient at a time. A Subscriber Trace Number is not needed on online Eligibility Requests.

AHCCCS Flow for the 270/271 Transaction Set



5. Transaction Specifications

5.1 About Transaction Specifications

Purpose

Transaction Specifications document the data elements and code set values that AHCCCS allows between trading partners and specify the type and format of transaction information. In some cases the values specified are subsets of the data element values listed or referenced in Implementation Guides. In others, they are specific to AHCCCS requirements.

For example, in the Subscriber Number Loop of a transaction in the Implementation Guide, Element NM109 is defined as an alphanumeric identification element that is between 1 and 30 characters long. In the Transaction Specifications, NM109 is defined as the member's AHCCCS ID. The length and format of the field are based on the characteristics of the AHCCCS Recipient ID rather than on the variable field size defined for the transaction by the more generic Implementation Guide.

Specifications for the 270 and the 271 Transactions accommodate both interactive and batch applications. Elements used in the interactive mode are, in most cases, a subset of batch elements. Interactive elements are shaded in the specification matrices for both 270 and 271 Transactions. Online responses with error conditions replace the code set values in AAA Segments with brief descriptions (e.g., Reject Reasons rather than Reject Reason Codes).

Relationship to HIPAA Implementation Guides

Transaction Specifications supplement information in the Implementation Guides for each HIPAA Transaction with additional information specific to the trading partners using the transaction.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 270 Eligibility Request Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify and describe the data elements used by requesters of electronic eligibility verification from AHCCCS on 270 Eligibility Request Transactions. Both interactive and batch versions of the transaction are accommodated in the 270 Specifications Matrix. Elements used in interactive transactions are shaded in the matrix.

Transaction Specifications Table

270 Eligibility Request Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

270 ELIGIBILITY VERIFICATION REQUEST TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	270	Eligibility, Coverage or Benefit Inquiry
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 270 transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 270 Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0022	Information Source, Information Receiver, Subscriber, Dependent The "0022" values is required in the 270/271 Implementation Guide even when Dependent Segments are not present.
N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	13	Request
N/A	BHT	BHT03	Submitter Transaction Identifier	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number assigned by the interactive 270 requester. Not used on batch transactions.
N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 270 Transaction is created in CCYYMMDD format.
N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSS format
2000A	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	1	For AHCCCS, the Agency is the sole source of information and this required element is always populated with a value of "1".
2000A	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	20	Information Source
2000A	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100A	NM1	NM103	Information Source Last or Organization Name	The organization name or the last name of an individual who is the source of the information	AHCCCS	The Organization Name of the information source

270 ELIGIBILITY VERIFICATION REQUEST TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's Identification Number
2100A	NM1	NM109	Information Source Primary Identifier	Identifies the number by which the information source is known to the information receiver	866004791	The AHCCCS Federal Tax ID of the information source
2000B	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	2	The HL Segment within the 2000B Information Receiver Level Loop is always for the second HL Segment in the transaction.
2000B	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	1	The level of the HL Segment to which this HL Segment is subordinate.
2000B	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	21	Information Receiver
2000B	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	1P	Provider
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100B	NM1	NM103	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		The "Organization Name" of the requester within this up to 35-character field even if the requester is an individual.
2100B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	XX XV SV	AHCCCS expects the NPI in NM109 in accordance with the standard HIPAA Implementation Guide. If the Provider has an NPI but does not provide it in NM109, the submission will be rejected during processing. XX = National Provider ID, Provider XV = National Provider ID, Payer (If HCFA National PlanID mandated) SV = Service Provider Number for those who do not qualify for a National Provider ID (only)

270 ELIGIBILITY VERIFICATION REQUEST TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100B	NM1	NM109	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query		The 10-character National Provider ID of the requestor (or the six-character AHCCCS Provider ID Number of the requestor if requestor does not have an NPI). See Appendix B – AHCCCS NPI Strategy
2100B	REF	REF01	Reference Identification Qualifier	AHCCCS requires an Information Receiver Additional Identification REF Segment on every batch 270 Request.	JD	User Identification
2100B	REF	REF02	Information Receiver Additional Identifier	Reference identification as needed		The requester's Web User ID created by the account creation process. Pad with leading zeros to create a seven-character field.
2000C	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	3 – nnn	For AHCCCS, this is the final HL Level within the 270 Transaction. For interactive requests, HL01 in the 2000C Loop will always have a value of "3". For batch 270 Transactions, with any number of patient eligibility requests, the value of HL01 in Loop 2000C begins with 3 and increases by 1 for each subsequent patient request.
2000C	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	2	For AHCCCS, the 2000C Subscriber Loop is always subordinate to the 2000B Information Receiver Loop.
2000C	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	22	Subscriber
2000C	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	0	No subordinate HL Segment in this hierarchical structure A subordinate segment would be at the dependent level – not used by AHCCCS.
2000C	TRN	TRN01	Trace Type Code	Code identifying which transaction is being referenced	1	Current Transaction Trace Numbers
2000C	TRN	TRN02	Trace Number	Unique identification for the patient request (2000C Loop)		On batch 270 Requests, a number assigned by the request submitter that is unique within the transaction. This number is returned on the 271 Response Transaction and can be used to link patient level requests and responses.
2000C	TRN	TRN03	Trace Assigning Entity Identifier	A unique identifier for the submitting entity		The number "1" following by the requester's nine-digit Federal Tax ID.
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IL	Insured or Subscriber
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person

270 ELIGIBILITY VERIFICATION REQUEST TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		The patient's Last Name if Last Name is used as a search criterion.
2100C	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		The patient's First Name if First Name is used as a search criterion.
2100C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	Member Identification Number Use this qualifier on batch transactions if the patient's AHCCCS ID is used as a search criterion.
2100C	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		The patient's AHCCCS ID if AHCCCS Recipient ID is used as a search criterion.
2100C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	SY	Social Security Number Use this qualifier on batch transactions if the patient's Social Security Number is used as a search criterion.
2100C	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		The patient's Social Security Number if SSN is used as a search criterion.
2100C	PRV	PRV01	Provider Code	Code indicating the role of the provider in the expected service		Any of the values in the 270/271 Implementation Guide are valid. "SB" (Submitting) is appropriate when the provider who will render the service is the same as the requester. "PE" (Performing) can be used for an individual service provider when the requester is a group entity.
2100C	PRV	PRV02	Provider Identification Qualifier	Code qualifying the reference identification	9K	Servicer
2100C	PRV	PRV03	Provider Identifier	The provider's identification number		The service provider's six-character Provider ID Number assigned by AHCCCS.
2100C	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD
2100C	DMG	DMG02	Subscriber Birth Date	The date of birth of the subscriber to the indicated coverage or policy		The patient's Date of Birth if Date of Birth is used as a search criterion.
2100C	DMG	DMG03	Subscriber Gender Code	Code indicating the sex of the subscriber to the indicated coverage or policy	M F	Male Female The patient's Gender if Gender is used as a search criterion

270 ELIGIBILITY VERIFICATION REQUEST TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	307, 435, 472	307 = Eligibility Date or Date Range 435 = Admission Date or Date Range 472 = Service Date or Date Range
2100C	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8 RD8	Date expressed in format CCYYMMDD Range of dates expressed in format CCYYMMDDCCYYMMDD
2100C	DTP	DTP03	Date Time Period	Expression of a date, a time, or a range of dates, times, or dates and times		The date or date range for which data is requested. For specific information regarding 1 day, RD8 should be used with an end date equal to the begin date. If D8 is used, it is assumed that the date of service is open-ended. For example, if today's date is 1/26/2004, and the user has supplied a D8 qualifier with the date of 12/01/2003, the response will return information from 12/01/2003 through 01/26/2004. It is recommended that RD8 be used to ensure that the corresponding eligibility, enrollment and other coverage is returned on the response.
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		The number of segments in the 270 Transaction, including ST and SE Segments
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		The same control number that appears in Element ST02 at the beginning of the transaction

5.3 271 Eligibility Response Transaction Specifications

Overview

The purpose of these Transaction Specifications is to identify the data elements used in the interactive and batch versions of the AHCCCS 271 Response Transaction. In both versions, the 271 Response has many more data elements than the 270 Request. This is true for two reasons:

- AHCCCS uses the 271 Response Transaction to give requesters eligibility, enrollment, Medicare, and TPL data for AHCCCS recipients. These elements do not appear on the 270 Request.
- Request Verification AAA Segments on 271 Transactions tell receivers why their 270 Request Transactions are in error. Additional data elements are needed to accomplish this.

There are also significant data variations between interactive and batch transactions, especially for the 271 Response. Control fields and qualifiers are not needed for data content compliance but are needed for the batch 270 and 271 formats. In addition, batch responses accommodate more data than interactive responses. This factor is shown clearly by the non-shaded elements (i.e., elements used only on batch transactions) in the 271 Eligibility Verification Response Transaction Specifications Matrix.

Error Codes

HIPAA compliant Reject Reason Codes and messages can appear in AAA Request Validation Segments on 271 Transactions in both interactive and batch modes (See Appendix A for a current list of codes).

In addition to the Reject Reason Codes (AAA02) and messages listed in Appendix A, AAA Request Validation Segments carry Valid Request Indicators (AAA01) and Follow-up Action Codes (AAA03). The Valid Request Indicator will be either "Y" or "N". The "Y" value means that there is nothing wrong with the 270 Request and only occurs in the interactive mode when the Reject Reason Code is "42" (Unable to respond at the current time). An "N" value means that there is something wrong with the transaction. For AHCCCS, the Follow-up Action Code is either "P" (Please resubmit original transaction [for a Reject Reason Code of "42"]) or "C" (Please Correct and Resubmit [for all other Reject Reason Codes]).

Transaction Specifications Table

271 Eligibility Verification Response Transaction Specifications for individual data elements are shown in the table beginning on the next page. Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
The valid data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	271	Eligibility, Coverage or Benefit Information
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set's functional group		The Transaction Set Control Number used in the ST02 Element of the 270 Request Transaction to which this 271 Transaction is sent in response.
N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0022	Information Source, Information Receiver, Subscriber, Dependent The "0022" values is required in the 270/271 Implementation Guide even when Dependent Segments are not present.
N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	11	Response
N/A	BHT	BHT03	Submitter Transaction Identifier	Trace or control number assigned by the originator of the transaction		The Transaction Identification Number submitted on the 270 Transaction.
N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 271 Transaction is created in CCYYMMDD format.
N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSSDD format
2000A	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	1	The 2000A Information Source Level Loop can occur multiple times, with different sequential values in Element HL01 when information on 271 Response Transactions is from multiple sources. For AHCCCS, the Agency is the sole source of information and this required element is always populated with a value of "1".
2000A	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	20	Information Source
2000A	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2000A	AAA	AAA01	Valid Request Indicator	Code indicating if the information request or portion of the request is valid or invalid	Y	Yes Use the AAA Request Validation data if a valid Request Transaction cannot be processed due to a connection problem. Only interactive transactions will be able to generate this data. Batch transaction processes, unlike interactive processes, are always "able to respond" when they are being executed by PMMIS

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000A	AAA	AAA03	Reject Reason Code	Code assigned by issuer to identify reason for rejection	See Appendix A	Data in this AAA Segment appears only on interactive Eligibility Response Transactions.
2000A	AAA	AAA04	Follow-up Action Code	Code identifying follow-up actions allowed	P	Please Resubmit Original Transaction Data in this AAA Segment appears only on interactive Eligibility Response Transactions.
2100A	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	PR	Payer
2100A	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100A	NM1	NM103	Information Source Last or Organization Name	The organization name or the last name of an individual who is the source of the information	AHCCCS	The Organization Name of the information source
2100A	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	FI	Federal Taxpayer's Identification Number
2100A	NM1	NM109	Information Source Primary Identifier	Identifies the number by which the information source is known to the information receiver	866004791	The AHCCCS Federal Tax ID
2100A	AAA	AAA01	Valid Request Indicator	Code indicating if the information request or portion of the request is valid or invalid	Y	Yes Use the AAA Request Validation Segment in Loop 2100A if a valid 270 Transaction cannot be processed due to a connection problem. Only interactive transactions will be able to generate this data. Batch transaction processes, unlike interactive processes, are always "able to respond" when they are being executed by PMMIS
2100A	AAA	AAA03	Reject Reason Code	Code assigned by issuer to identify reason for rejection	See Appendix A	Data in this AAA Segment appears only on interactive Eligibility Response Transactions.
2100A	AAA	AAA04	Follow-up Action Code	Code identifying follow-up actions allowed	P	Please Resubmit Original Transaction Data in this AAA Segment appears only on interactive Eligibility Response Transactions.
2000B	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	2	The HL Segment within the 2000B Information Receiver Level Loop is always for the second HL Segment in the transaction. AHCCCS does not accept or respond to 270 Transactions from multiple requesters or "information receivers."

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2000B	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	1	The level of the HL Segment to which this HL Segment is subordinate.
2000B	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	21	Information Receiver
2000B	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	1	Additional subordinate HL Data Segment in this hierarchical structure
2100B	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	1P	Provider
2100B	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2100B	NM1	NM103	Information Receiver Last or Organization Name	The name of the organization or last name of the individual that expects to receive information or is receiving information		The “Organization Name” of the requester from the 270 Request.
2100B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	XX XV SV	XX = National Provider ID, Provider XV = National Provider ID, Payer SV = Service Provider Number for those who do not qualify for a National Provider ID (only)
2100B	NM1	NM109	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query		The 10-character National Provider ID of the requestor (or the six-character AHCCCS Provider ID Number of the requestor if requestor does not have an NPI). See Appendix B – AHCCCS NPI Strategy
2100B	REF	REF01	Reference Identification Qualifier	AHCCCS returns an Information Receiver Additional Identification REF Segment on every batch 271 Response.	JD	User Identification
2100B	REF	REF02	Information Receiver Additional Identifier	Reference identification as needed		The requester’s Web User ID (a seven-digit number padded with leading zeros) created by the AHCCCS account creation process and submitted on the 270 Request. The field is not used in the batch FTP process.
2100B	AAA	AAA01	Valid Request Indicator	Code indicating if the information request or portion of the request is valid or invalid	N	No If the transaction is rejected due to a data error within the 2100B Loop, AAA01 has a value of “N”.

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100B	AAA	AAA03	Reject Reason Code	Code assigned by issuer to identify reason for rejection	See Appendix A	See Appendix A
2100B	AAA	AAA04	Follow-up Action Code	Code identifying follow-up actions allowed	C	Please Correct and Resubmit
2000C	HL	HL01	Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	3 – nnn	For AHCCCS, this is the final HL Level within the 270 Transaction. For interactive requests, HL01 in the 2000C Loop will always have a value of "3". For batch 270 Transaction, with any number of patient eligibility requests, the value of HL01 in Loop 2000C begins with 3 and increases by 1 for each patient request.
2000C	HL	HL02	Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	2	For AHCCCS, the 2000C Subscriber Loop is always subordinate to the 2000B Information Receiver Loop.
2000C	HL	HL03	Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure	22	Subscriber
2000C	HL	HL04	Hierarchical Child Code	Code indicating if there are hierarchical child data segments subordinate to the level being described	0	No subordinate HL Segment in this hierarchical structure A subordinate segment would be at the dependent level – not used by AHCCCS.
2000C	TRN	TRN01	Trace Type Code	Code identifying which transaction is being referenced	2	Referenced Transaction Trace Numbers
2000C	TRN	TRN02	Trace Number	Unique identification for the patient request (2000C Loop)		On batch 271 Responses, a number assigned by the request submitter that is unique within the 270 Transaction. This number is returned on the 271 Response Transaction and can be used to link patient level requests and responses.
2000C	TRN	TRN03	Trace Assigning Entity Identifier	A unique identifier for the submitting entity		The number "1" following by the requester's nine-digit Federal Tax ID. Transferred from the Request.
2100C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	IL	Insured or Subscriber
2100C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	1	Person
2100C	NM1	NM103	Subscriber Last Name	The surname of the insured individual or subscriber to the coverage		The recipient's Last Name as it appears on the AHCCCS Database.
2100C	NM1	NM104	Subscriber First Name	The first name of the insured individual or subscriber to the coverage		The recipient's First Name as it appears on the AHCCCS Database.

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	NM1	NM105	Subscriber Middle Name	The middle name of the subscriber to the indicated coverage or policy		The recipients Middle Initial if it appears on the AHCCCS Database.
2100C	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	MI	Member Identification Number
2100C	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		The recipient's AHCCCS ID
2100C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	SY NQ	Social Security Number Medicaid Recipient Identification Number AHCCCS populates this situational REF Segment in two situations: ▪ When a recipient's SSN is submitted on a 270 Request Transaction and used in a successful search (REF01 = "SY"). ▪ When the recipient has a Primary AHCCCS ID that is different from the AHCCCS ID submitted on the 270 Transaction and used in the recipient search (REF01 = "NQ").
2100C	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		The recipient's SSN or Primary AHCCCS ID when appropriate. See above.
2100C	N3	N301	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		The first line of the recipient's street address.
2100C	N3	N302	Subscriber Address Line	Address line of the current mailing address of the insured individual or subscriber to the coverage		The second line of the recipient street address (if present).
2100C	N4	N401	Subscriber City Name	The City Name of the insured individual or subscriber to the coverage		The recipient's city
2100C	N4	N402	Subscriber State Code	The State Postal Code of the insured individual or subscriber to the coverage		The recipient's State Code
2100C	N4	N403	Subscriber Postal Zone or ZIP Code	The ZIP Code of the insured individual or subscriber to the coverage		The recipient's Zip Code (can be five or nine digits)
2100C	N4	N405	Location Qualifier	Code identifying type of location	CY	County
2100C	N4	N406	Location Identification Code	Code which identifies a specific location		The County Code for the recipient's home address.

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2100C	AAA	AAA01	Valid Request Indicator	Code indicating if the information request or portion of the request is valid or invalid	N	No If the transaction is rejected due to a data error within the 2100C Loop, AAA01 has a value of "N".
2100C	AAA	AAA03	Reject Reason Code	Code assigned by issuer to identify reason for rejection	See Appendix A	See Appendix A
2100C	AAA	AAA04	Follow-up Action Code	Code identifying follow-up actions allowed	C	Please correct and resubmit
2100C	DMG	DMG01	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8	Date expressed in format CCYYMMDD
2100C	DMG	DMG02	Subscriber Birth Date	The date of birth of the subscriber to the indicated coverage or policy		The patient's Date of Birth if Date of Birth from the AHCCCS Database
2100C	DMG	DMG03	Subscriber Gender Code	Code indicating the sex of the subscriber to the indicated coverage or policy	M F	Male Female The patient's Gender from the AHCCCS Database
2100C	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	472	Service Date or Date Range
2100C	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8 RD8	Date expressed in format CCYYMMDD Range of dates expressed in format CCYYMMDDCCYYMMDD
2100C	DTP	DTP03	Date Time Period	Expression of a date, a time, or a range of dates, times, or dates and times		The date or date range for which recipient data was requested on the 270 Request Transaction.

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110C	EB	EB01	Eligibility or Benefit Information	Benefit status of the individual or benefit related category to be further described in the transaction	1 6 R	The EB Segment and the EB01 Element begin the 2110C Subscriber Eligibility or Benefit Loop. This loop is used by AHCCCS to carry eligibility, health plan enrollment, Medicare, and/or TPL data, depending on the value of EB04 Insurance Type Code. The 2110C Loop can occur any number of times for a recipient. Active Coverage (AHCCCS eligibility and health plan enrollment - Returned when an DTP03 End Date is not present or is on or after the current date) Inactive (AHCCCS eligibility and health plan enrollment - Returned when an DTP03 End Date is present and is before the current date) Other or Additional Payer (Medicare and TPL – Can have a Begin Date and/or an End Date in DTP03)
2110C	EB	EB02	Benefit Coverage Level Code	Code indicating which family members are provided coverage for this insured	IND	Individual AHCCCS recipients are always considered individuals rather than dependents of a primary subscriber.
2110C	EB	EB03	Service Type Code	Code identifying the classification of service	30 88	Health Benefit Plan Coverage Pharmacy Benefit (for Medicare Part D)
2110C	EB	EB04	Insurance Type Code	Code identifying the type of insurance	 MC HM MA MB MP C1	This element identifies the kind of eligibility or benefit information that appears in the 2110C Eligibility or Benefit Loop. Although the field is shown as situational in the 270/271 Implementation Guide, it is always populated by AHCCCS. The valid values listed before are used for AHCCCS: Medicaid (the 2110C Loop is for AHCCCS eligibility) HMO (the 2110C Loop is for health plan enrollment) Medicare Part A (the 2110C Loop is for Medicare Part A eligibility) Medicare Part B (the 2110C Loop is for Medicare Part B eligibility) Medicare Part D (the 2110C Loop is for Medicare Part D eligibility) Commercial (the 2110C Loop is for third party coverage)
2110C	EB	EB05	Plan Coverage Description	A description or number that identifies the plan or coverage		On Eligibility EB Segments (when EB04 = “MC”), EB05 is the Eligibility Description (X[38]) On Health Plan Enrollment EB Segments (when EB04 = “HM”), EB05 is the Contract Type (X[12])

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						This situational element does not appear for other types of EB Segments.
2110C	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F6 1L	Health Insurance Claim (HIC) Number (AHCCCS uses this value when EB04 = "MA" or "MB") Group or Policy Number (AHCCCS uses this value when EB04 = "C1")
2110C	REF	REF02	Subscriber Eligibility or Benefit Identifier	Number associated with the subscriber for the eligibility or benefit being described		For a Medicare EB Segment (EB04 = "MA" or "MB" or "MP"), the Medicare Claim ID Number (X[12]). For a TPL Segment (EB04 = "C1"), the other carrier's Policy Number (X[15]).
2110C	REF	REF03	Plan Sponsor Name	The name of the entity providing coverage to the subscriber		For a TPL Segment (EB04="C1"), the name of the TPL carrier.
2110C	DTP	DTP01	Date Time Qualifier	Code specifying the type of date or time or both date and time	 307 292 290 318	The Subscriber Eligibility/Benefit Date DTP Segment in the 2110C Loop is used in the situations described below. Eligibility Date(s) (when EB04 = "MC") Benefit Date(s) (when EB04 = "MA" or "MB") Coordination of Benefit (when EB04 = "C1") Added Date (valid for all EB04 values in addition to a DTP Segments with another DTP01 value)
2110C	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format	D8 RD8	Date expressed in format CCYYMMDD Range of dates expressed in format CCYYMMDDCCYYMMDD AHCCCS uses one of these values, depending on whether the information is current or historical. The Added Date (when DTP01="318) is always a single date rather than a date range.
2110C	DTP	DTP03	Eligibility or Benefit Date Time Period	Date or period associated with the eligibility or benefit being described		The date or date range identified by the above qualifiers.
2110C	AAA	AAA01	Valid Request Indicator	Code indicating if the information request or portion of the request is valid or invalid	N	No If the transaction is rejected due to a data error within the 2110C Loop, AAA01 has a value of "N".
2110C	AAA	AAA03	Reject Reason Code	Code assigned by issuer to identify reason for rejection	See Appendix A	See Appendix A
2110C	AAA	AAA04	Follow-up Action Code	Code identifying follow-up actions allowed	C	Please correct and resubmit

271 ELIGIBILITY VERIFICATION RESPONSE TRANSACTION SPECIFICATIONS – Data used in online transactions is shaded.						
Loop ID	**Segment ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2110C	MSG	MSG01	Free-form Message Text	A free-form message		On 2110C Loops for health plan enrollments (EB04 = "HM"), the Rate Code (X[4]) and the Rate Code Description (X[30])
2110C	LS	LS01	Loop Identifier Code	The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	2120	A value assigned by the Implementation Guide to identify the beginning of the 2120C Subscriber Benefit Related Entity Name Loop AHCCCS uses the 2120C Loop to identify lock-in provider for locked in recipients (possible when EB01 = "MC") and nursing home providers for recipients who are nursing home resident (possible for all EB04 values except "C1")
2120C	NM1	NM101	Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	1P FA	Provider (used for lock-in providers) Facility (used for nursing home residents)
2120C	NM1	NM102	Entity Type Qualifier	Code qualifying the type of entity	2	Non-Person Entity
2120C	NM1	NM103	Benefit Related Entity Last or Organization Name	Last name or organization name of the benefit related entity associated with an individual subscriber or dependent		The name of the lock-in provider or nursing home
2110C	LE	LE01	Loop Identifier Code	The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	2120	A value assigned by the Implementation Guide to identify the end of the 2120C Subscriber Benefit Related Entity Name Loop
N/A	SE	SE01	Transaction Segment Count	A tally of all segments between the ST and the SE segments including the ST and SE segments		The number of segments in the 271 Transaction
N/A	SE	SE02	Transaction Set Control Number	The unique identification number within a transaction set		The same control number that is present in ST02 at the beginning of the transaction

6. Appendices

6.1. Appendix A

HIPAA Compliant Reject Reason Codes

Code	Meaning
15	Required application data missing (appears when there is missing data on the 270 submitter)
42	Unable to respond at the current time (interactive transactions only)
43	Missing/Invalid Provider Identification (appears when provider submitted his 270 using his AHCCCS Provider ID instead of his NPI number)
51	Provider not on file (appears when the requesting provider is not recognized by AHCCCS)
57	Invalid/Missing Dates of Service (appears when a Date of Service on the 270 Request is invalid)
58	Invalid/Missing Date of Birth (appears when a Date of Birth on the 270 Request is invalid)
65	Invalid/Missing Patient Name (appears when a First Name or Last Name on the 270 Request is invalid or is missing when related search elements [Date of Birth and Gender] are present)
66	Invalid/Missing Patient Gender Code (appears when a Gender Code on the 270 Request is invalid)
67	Patient Not Found (appears when search criteria are present but cannot be used to identify an AHCCCS recipient)

6.2. Appendix B

AHCCCS NPI Strategy.

The Executive Committee strategic direction for this project is to accept the NPI on all incoming transactions and/or interfaces, convert to the internal PMMIS Provider Registration Number used today for internal processing and either re-convert back to the NPI or use the NPI submitted on the incoming transaction when reporting back to the submitter. The goal is to make only those changes to PMMIS that are required by business processes. All internal processing will continue to be done using the existing PMMIS Provider Registration Number.

Modify PMMIS to recognize and use the National Provider Identifier (NPI) in place of the existing 6 digit PMMIS Assigned Provider Registration Number for eligible providers. By national mandate the NPI will be the single provider identifier, for HIPAA Covered Entities, replacing the different provider identifiers currently in use. HIPAA covered entities are health care providers or their agents that conduct electronic transactions for which the Secretary has adopted a standard (i.e., standard transactions.) Atypical providers [those providers who do not provide traditional health care services such as non-emergency transportation] will not be eligible for a NPI and will continue to use the existing AHCCCS Provider Registration Number.

AHCCCS began accepting and loading NPIs from providers in 2005. AHCCCS will begin accepting NPIs on all transactions as of January 1, 2007. Processing rules are as follows:

- NPI sent prior to January 1, 2007 will cause the transaction to fail in the application system for Invalid Provider.
- After January 1, 2007, if an NPI is sent, the NPI will be used to process the transaction. If the NPI is not on the PMMIS file, the transaction will fail for invalid provider. If an NPI is sent, the NPI will be returned on outbound transactions, e.g., if an NPI is sent on the 270 the NPI will be returned on the 271 or 837/835.
- On and after May 23, 2007, for a provider that AHCCCS believes is/was eligible for an NPI and no NPI is present on the transaction – the transaction will fail for invalid provider.

Background.

On January 23, 2004, HHS published the Final Rule that adopts the National Provider Identifier (the NPI) as the standard unique health identifier for health care providers. The mandated compliance date is no later than 16 months after its publication date, May 23, 2007. The standard unique health identifier is mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Use of the NPI will reduce costs and improve efficiency in the nation's health care system by eliminating the need for health care providers to maintain, keep track of, and use multiple identification numbers assigned by the various health plans they bill.

The compliance date for all covered entities except small health plans is May 23, 2007; the compliance date for small health plans is May 23, 2008. Adoption of the standard health care provider identifier enables a provider to use only one identifier – its NPI – to identify itself in all standard transactions. Legacy numbers (e.g., UPIN, Blue Cross and Blue Shield

Numbers, CHAMPUS Number, Medicaid Number, etc.) will not be permitted. Providers will no longer have to keep track of multiple numbers to identify themselves in standard transactions with one or more health plans. (The Taxpayer Identifying Number may need to be reported for tax purposes as required by the implementation specifications. The DEA ID for controlled substances is not replaced by the NPI.)

All entities who meet the definition of "health care provider" at 45 CFR 160.103 are eligible for NPI's. Providers who are "covered entities" are required to obtain and use NPI's. A health care provider will be assigned only one NPI, and that NPI will not change over time. Providers who are not covered entities may also apply for NPI's. An NPI is expected to last indefinitely; it will not change over time.

In certain situations, it is possible for "subparts" of organization health care providers (such as hospitals) to be assigned NPI's. These subparts may need to be assigned NPI's in order to conduct standard transactions on their own behalf or to meet regulations that, as an example, may require them to have a billing number in order to be paid by Medicare. The Final Rule requires covered providers to determine if they have subparts that may need NPI's and, if so, to obtain NPI's for the subparts or require the subparts to obtain their own NPI's. (This issue does not pertain to providers who are individuals.)

Entities who do not provide health care (such as taxi services) are not eligible to be assigned NPI's: they do not meet the definition of "health care provider" and any claims they submit to a health plan would not be "health care" claims and thus would not be subject to HIPAA requirements, therefore, the solution must allow for continued use of the H/PMMIS Provider Registration Number.

The NPI is all numeric. It is 10 positions in length (9 plus a check-digit in the last position). It is easily accommodated in all standard transactions. It contains no embedded information about the provider that it identifies. At the current rate of provider growth, NPI's will be available for 200 years.

Providers will be assigned NPI's upon successful completion of an application form. The form can be submitted on paper or over the Internet. Once a provider has been assigned an NPI, the provider must furnish updates to its data within 30 days of any changes.

The National Plan and Provider System [NPPES] will process the applications and updates, ensure the uniqueness of the provider, and generate the NPI's. It will also produce reports and information based on requests from the health care industry and others.

A single entity, known as the enumerator will operate the NPPES. The enumerator will receive applications and updates from providers. Other responsibilities of the enumerator will be to assist providers in completing applications, in furnishing updates, and will be responsible for resolving problems and answering questions. Providers will receive confirmation of their NPI's directly from the enumerator. The enumerator will also process requests for, and disseminate information containing, providers' NPI's. The Department will prepare a Federal Register Notice describing the NPPES data dissemination policy.

Providers who are covered entities may begin applying for NPI's on May 23, 2005, the effective date of the Final Rule. There will be an extremely heavy workload continuing for

some time after that date as the NPS processes applications and assigns NPI's to existing providers who are required to obtain and use NPI's by the compliance date.

The NPI does not replace the registration process required by AHCCCS. Providers must continue to apply and register as they have in the past.

The NPI will not identify providers who work together within a group. Providers will have to continue to inform the Agency of 'group practice' situations and agency individuals will continue to have to 'link' providers.

Adoption of NPI is the latest step in implementing the administrative simplification provisions of HIPAA. The Secretary already has adopted standards for electronic transactions and code sets, for the privacy and security of certain individually identifiable health information, and for the unique health identifiers for employers. In the future, the Secretary will adopt standards for unique identifiers for health plans and for claims attachment transactions.

Business Benefit / Impact

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers for identifying themselves when conducting standard transactions with multiple health plans.

Benefits for the agency include:

- Identification of a provider across multiple health plans, agencies or organizations [improved fraud and abuse reporting]
- Improved COB processing
- Facilitates utilization review between organizations [such as the UMO contracted by AHCCCS]
- Facilitates prior authorization between organizations [such as contracted health plans]
- The ability for a group practice to enumerate and receive a NPI will allow multiple groups within one tax id to be recognized within PMMIS. The existing claim transactions provide the ability to send both the Group NPI and Tax Identifier Number for the billing provider.

Business Rules Affected

- Paper claims and standard transactions will use only the NPI for those covered entities that are eligible to receive one.
- AHCCCS will require that all providers who can enumerate; must. This will help ensure that providers who appear on standard transactions as supplemental providers will/can be identified using the NPI rather than other identifiers and forcing providers to submit paper claims/transactions.
- Groups with an NPI will be required to bill using the actual rendering provider NPI [the NPI will not be allowed at the rendering provider level within transactions].

270

If NPI is sent:

270 Eligibility Benefit Inquiry, 004010X092A1

Loop	Data Element	Name	Expected Value
2100B		INFORMATION RECEIVER	
	NM108	Identification Code Qualifier	"XX"
	NM109	Information Receiver Identification Number	NPI
[The following REF segment is not required, but may be sent. It will not be returned]			
	REF01	Reference Identification Qualifier [Medicaid Provider Number]	"1D"
	REF02	Information Receiver Additional Information	Legacy ID

If NPI is not sent:

270 Eligibility Benefit Inquiry, 004010X092A1

Loop	Data Element	Name	Expected Value
2100B		INFORMATION RECEIVER	
	NM108	Identification Code Qualifier [Service Provider Number]	"SV"
	NM109	Information Receiver Identification Number [Medicaid Provider Number]	Legacy ID

271

If NPI sent:

271 Eligibility Benefit Response, 004010X092A1

Loop	Data Element	Name	Expected Value
2100B		INFORMATION RECEIVER	
	NM108	Identification Code Qualifier	"XX"
	NM109	Information Receiver Identification Number	NPI
[The following REF segment is not required, but may be sent. It will not be returned]			
	REF01	Reference Identification Qualifier [Medicaid Provider Number]	"1D"
	REF02	Information Receiver Additional Information	Legacy ID